**Eastside Chiropractic, P.C.**
1011 Woodridge Lane, Building 301
Watkinsville, Georgia 30677
Dr. Bryan Hooper

# Financial and Insurance Policy

**It is the patient's responsibility to ensure that we have complete and accurate insurance and contact information when you check in for each visit. Any unpaid claims due to misinformation given to us will result in the patient being held financially responsible for services rendered.**

1. Our office agrees to verify your insurance benefits and eligibility to determine what chiropractic treatments are covered under your policy. In addition, we verify any copay, deductible, or coinsurance that applies. **Verification of benefits does not guarantee payment.**
2. **Payment is due at time of service.** No exceptions. This includes copays, deductibles, and noninsurance charges.
3. **Patients with insurance:** We agree to bill only insurance companies with whom we are contracted and considered in-network. Discounts and other incentives we offer cannot be combined with insurance. After claims are filed and processed, **you will be billed for any remaining balance.** We expect bills to be paid within 30 days.
4. **Patients with Medicare:** We will have you sign the **Medicare Coverage for Chiropractic Care Agreement**
5. **Patients without insurance:** We offer non-insurance rates for uninsured patients.
6. **Personal Injury patients:** We do not accept liens. We will accept the non-insurance rate per visit or we will agree to file through your insurance company.
7. **Methods of payment:** We accept cash, checks, and all major credit cards. We do not accept postdated checks.
8. **Collections:** Accounts that are not paid within 30 days will be turned over to a collection service. Should you discontinue care for any reason, your entire balance will become due immediately.
9. **Cancellation fee:** Appointments canceled in less than 24 hrs of the scheduled appointment time will be assessed a $25 late cancellation fee. Patients who no-show for appointments more than three times risk being dismissed from the practice.
10. **Dismissal:** We reserve the right to dismiss patients for excessive appointment cancelations, missed appointments without notification, and refusal to settle their account balance.

I have read and understand the policies stated above and agree to be bound by them by signing this document.

_____ _____

Patient's signature (or legal guardian) Patient's Printed Name

Date: _____